General Assembly

Raised Bill No. 1353

January Session, 2005

LCO No. **4834**

*04834_____PH_*

Referred to Committee on Public Health

Introduced by:
(PH)

AN ACT EXPANDING THE AVAILABILITY OF HEALTH INSURANCE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective October 1, 2005*) (a) As used in sections 1 to 3, inclusive, of this act:

(1) "Administrative services fee" means any required payment made by an individual for the purpose of defraying the administrative costs of the plan;

(2) "Capitation" means a payment system in which enrollees pay a fixed monthly fee to a managed care organization in return for the provision of a specific range of services for a contract year;

(3) "Coinsurance" means the sharing of health care expenses by the insured and an insurer in a specified ratio;

(4) "Commissioner" means the Commissioner of Social Services;

(5) "Copayment" means a payment made on behalf of an enrollee for a specified service under the plan;

(6) "Department" means the Department of Social Services;

(7) "Eligible business" means a small employer, as defined in section 38a-564 of the general statutes, and includes, but is not limited to, a municipality that has fifty or fewer employees;

(8) "Eligible individual" means a person who is nineteen years of age or older, has an income that exceeds one hundred per cent of the federal poverty level when income is calculated as provided in section 17b-261 of the general statutes, and is: (A) A self-employed individual (i) who works and resides in the state, (ii) who is organized as a sole proprietorship or in any other legally recognized manner, and (iii) whose primary source of income derives from a trade or business through which the individual has attempted to earn taxable income; (B) an unemployed individual who resides in this state; or (C) an individual employed in an eligible business that does not offer health insurance;

(9) "Enrollee" means an eligible individual who receives services from a managed care organization under the plan;

(10) "Plan" means the affordable health insurance plan established pursuant to sections 1 to 3, inclusive, of this act;

(11) "Managed care organization" means an entity that contracts with the department to offer a plan providing benefits to enrollees on a prepaid basis; and

(12) "Premium" means any required payment made by an enrollee to pay in full the capitation rate under the plan.

(b) The commissioner shall establish an affordable health insurance plan that shall, after start-up costs, be paid for by the enrollees, except as provided in subsection (d) of this section, through premiums and administrative services fees. An eligible individual may apply for enrollment in such plan if such individual (1) was uninsured as of January 1, 2005, or is employed by an eligible business, and (2) is

uninsured on the date of the application for enrollment.

(c) Except as provided in subsection (d) of this section, an applicant for enrollment in the plan shall, at the time of application, be required to pay a fifty-dollar application fee to the department. An enrollee shall, annually, upon reenrollment, pay a fifty-dollar enrollment fee and an administrative services fee to the department in accordance with the provisions of subsection (h) of this section.

(d) An eligible business may pay, on behalf of an employee, any fees or premiums charged to such employee who has enrolled in the affordable health insurance plan.

(e) (1) The commissioner shall enter into a contract with an entity to be a single point of entry servicer for applicants and enrollees under the plan. The servicer shall enroll eligible individuals in such individual's choice of managed care organization. Such servicer shall electronically transmit data with respect to enrollment and disenrollment in the plan to the commissioner.

(2) The commissioner or, at the commissioner's discretion, the single point of entry servicer shall review applications for eligibility to determine whether applicants or employers of applicants have discontinued employer-sponsored coverage for the purpose of participation in the plan.

(3) An application may be disapproved if it is determined that an applicant was covered by an employer-sponsored insurance within four months prior to the date of application. If the commissioner determines that the time period specified in this subsection is insufficient to effectively deter applicants or employers of applicants from discontinuing employer-sponsored coverage for the purpose of participation in the plan, the commissioner may extend such period for a maximum of an additional two months.

(4) An application may be approved in cases where prior employer-

sponsored coverage ended less than four months prior to the date of application, for reasons unrelated to the availability of the plan, including, but not limited to:

(A) Loss of employment due to factors other than voluntary termination;

(B) Change to a new employer that does not provide an option for health benefits;

(C) Change of address so that no employer-sponsored coverage is available;

(D) Discontinuation of health benefits to all employees of the applicant's employer;

(E) Expiration of the coverage periods established by the Consolidated Omnibus Budget Reconciliation Act of 1985, (P.L. 99-272) as amended from time to time, (COBRA);

(F) Self-employment;

(G) Termination of health benefits due to a long-term disability;

(H) Termination of health benefits due to an extreme economic hardship on the part of either the employee or the employer, as determined by the commissioner; or

(I) Substantial reduction in either lifetime medical benefits or benefit category available to an employee under an employer's health care plan.

(f) The plan shall provide all benefits mandated by state or federal law. The commissioner may apply an exclusion for preexisting conditions, as permitted by federal or state law. The commissioner may impose lifetime or annual benefit maximums and limitations on the amount, duration and scope of benefits under the plan, and may establish a schedule of copayments and coinsurance for coverage

provided under the plan.

(g) The commissioner shall require the payment of a premium in connection with services provided under the plan in accordance with the following limitations: (1) On or before September 1, 2006, and annually thereafter, the commissioner shall establish a schedule for the maximum aggregate premium for individuals enrolling in the plan, and (2) the commissioner shall require each managed care organization to monitor premiums under the provisions of this section.

(h) (1) The administrative services fee shall be sufficient to cover the administrative costs of the plan and the outreach costs incurred pursuant to section 3 of this act. On or before August 15, 2005, and prior to the establishment of premium schedules for enrollees in the plan program for the first year, the commissioner shall calculate (A) administrative costs to be incurred by the department in the implementation and development of the plan, (B) the anticipated administrative costs for routine operation of the plan for the first year, and (C) an amount to be used to reimburse the General Fund for the first year for the start-up costs of the affordable health insurance plan administrative costs account established pursuant to section 2 of this act. On or before August 15, 2006, and annually thereafter, the commissioner shall calculate the anticipated administrative costs for routine operation of the plan for the year and an amount to be used to reimburse the General Fund for the year for the start-up costs of said account established pursuant to section 2 of this act.

(2) Administrative costs calculated by the commissioner pursuant to subdivision (1) of this section shall be paid for by moneys deposited in said account established pursuant to section 2 of this act.

(i) (1) On or before September 1, 2005, the commissioner shall enter into contracts with managed care organizations to provide the services described in subsection (f) of this section to enrollees in the plan. Such contracts shall require the establishment of an internal quality assurance plan by each managed care organization which shall be in

writing and available to the public.

(2) Each managed care organization shall include sufficient numbers of appropriately trained and certified clinicians, including primary, medical subspecialty and surgical specialty physicians, as well as providers of necessary related services to assure enrollees the option of obtaining benefits through such providers.

(3) Each managed care organization that enters into a contract with the department pursuant to subdivision (1) of this subsection to provide comprehensive services under the plan, shall have primary responsibility for ensuring that its behavioral health and dental subcontractors adhere to the contract between the department and the managed care organization, including the provision of timely payments to providers and interest payments in accordance with subdivision (15) of section 38a-816 of the general statutes. The managed care organization shall submit to the department a claims aging inventory report including all data on all services paid by subcontractors in accordance with the terms of the contract with the department.

(4) Upon the initial contract or the renewal of a contract between a managed care organization and a behavioral health or dental subcontractor, the department shall require that the managed care organizations impose a performance bond, letter of credit, statement of financial reserves or payment withhold for behavioral health and dental subcontractors that provide services under the plan. Any such performance bond, letter of credit, statement of financial reserves or payment withhold that may be required by the department pursuant to a contract with a managed care organization shall be in an amount sufficient to assure the settlement of provider claims in the event that the contract between the managed care organization and the behavioral health or dental subcontractor is terminated. Upon the initial contract or the renewal of a contract between a managed care organization and a behavioral health or dental subcontractor, the

managed care organization shall negotiate and enter into a contract termination agreement with its behavioral health and dental subcontractors that shall include, but not be limited to, provisions concerning financial responsibility for the final settlement of provider claims and data reporting to the department. The managed care organization shall submit reports to the department, at such times as the department shall determine, concerning any payments made from such performance bond or any payment withholds, the timeliness of claim payments to providers and the payment of any interest to providers.

(j) (1) The commissioner shall contract for the external quality review of the plan. Such review shall include, but need not be limited to, an evaluation of access to care, medical record standards, provider credentialing and individual case review.

(2) The commissioner may impose the following sanctions on any managed care organization which does not meet the quality of care required by regulations adopted pursuant to subsection (l) of this section or the standards developed for external quality review by a contract under the provisions of subdivision (1) of this subsection:

(A) Require the managed care organization to submit and implement a plan of correction;

(B) Limit new enrollment during any period of noncompliance;

(C) Withhold state payments that may become due until the deficiencies are corrected; or

(D) Prohibit the managed care organization from renewing or entering into new contracts to serve enrollees.

(k) Any payment made by the state on behalf of an enrollee as a result of any false statement, misrepresentation or concealment of or failure to disclose income or health insurance coverage by an applicant may be recovered by the state.

(l) (1) The commissioner shall adopt regulations, in accordance with chapter 54 of the general statutes, necessary to implement the provisions of this section, including, but not limited to, the establishment of residency requirements, methods for determining income eligibility for participation in the plan, procedures for a simplified mail-in application process, appropriate contract standards to oversee and ensure the quality of care provided by managed care organizations under the plan, and criteria for assessing the outcomes of health care provided to enrollees in the plan.

(2) The commissioner shall implement the policies and procedures necessary to carry out the provisions of this section, while in the process of adopting such policies and procedures in regulation form, provided notice of intent to adopt the regulations is published in the Connecticut Law Journal no later than twenty days after implementation. Such policies and procedures shall be valid until the time final regulations are effective.

(m) On or before January 1, 2006, and annually thereafter, the commissioner shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health and insurance regarding the establishment and operation of the plan established by this section.

Sec. 2. (NEW) (*Effective from passage*) (a) There is established, within the General Fund, a separate, nonlapsing account to be known as the "affordable health insurance plan administrative costs account". Moneys received by the Department of Social Services pursuant to subsection (c) of section 1 of this act shall be deposited in the account. The account shall also contain any funds received pursuant to subsection (c) of this section. Investment earnings credited to the assets of the account shall become part of the assets of the account. Any balance remaining in the account at the end of any fiscal year shall be carried forward for the fiscal year next succeeding. The moneys in said

account shall be used to pay for administrative costs incurred by the department through the development, implementation and routine operation of the plan and to reimburse the General Fund in accordance with subsection (b) of this section.

(b) On or before July 1, 2006, and annually thereafter, the Commissioner of Social Services, in accordance with the provisions of subsection (h) of section 1 of this act, shall allocate a percentage of administrative fees to reimburse the General Fund for the start-up costs for the plan.

(c) The Commissioner of Social Services, subject to any limitations otherwise imposed by law, may receive and accept on behalf of the state for deposit in the account, any funds which may be offered or which may become available from federal grants or appropriation, private gifts, donations or bequests, or from any other source, for purposes of section 1 of this act.

Sec. 3. (NEW) (*Effective from passage*) (a) The Commissioner of Social Services, in consultation with the Labor Commissioner and the Commissioners of Economic and Community Development and Public Health, shall develop mechanisms for outreach for the affordable health insurance plan established pursuant to section 1 of this act, including, but not limited to, publicizing the availability of such plan, the eligibility criteria and how to apply for enrollment, development of mail-in applications and appropriate outreach materials through the Departments of Revenue Services, Social Services, Economic and Community Development and Public Health and the Labor Department.

(b) All such outreach materials shall be approved by the Commissioner of Social Services.

Sec. 4. (NEW) (*Effective October 1, 2005*) As used in sections 4 to 10, inclusive, of this act:

(1) "Dependent" means the spouse, domestic partner, minor child of a covered enrollee, or child eighteen years of age or over who is dependent on the enrollee, as specified by the commissioner, but does not mean a dependent who is provided coverage by another employer or who is an eligible enrollee as a consequence of such dependent's employment status;

(2) "Enrollee" means a person who works at least one hundred hours per month for any individual employer and has worked for that employer for three months, and includes sole proprietors or partners of a partnership if they are actively engaged at least one hundred hours per month in the business of the proprietorship or partnership;

(3) "Large employer" means a person, as defined in Section 7701(a) of the Internal Revenue Code, or public or private entity employing for wages or salary one thousand or more persons to work in this state;

(4) "Employer" means an employer subject to chapter 567 of the general statutes that is a large employer, and includes all of the members of a controlled group of corporations, as defined in Section 1563(a) of the Internal Revenue Code, except that "more than 50 per cent" shall be substituted for "at least 80 per cent" each place it appears in Section 1563(a)(1) of the Internal Revenue Code and the determination shall be made without regard to Sections 1563(a)(4) and 1563(e)(3)(C) of the Internal Revenue Code;

(5) "Principal employer" means the employer for whom an enrollee works the greatest number of hours in any month;

(6) "Wages" means wages paid directly to an individual by his or her employer;

(7) "Program" means the State Health Insurance Purchasing Program; and

(8) "Fee" means the fee as determined in section 7 of this act.

Sec. 5. (NEW) (*Effective October 1, 2005*) (a) On and after January 1, 2007, large employers shall comply with the provisions of sections 4 to 10, inclusive, of this act.

(b) Sections 4 to 10, inclusive, of this act shall not be construed to diminish any health care coverage provided pursuant to collective bargaining agreements or employer-sponsored plans that are more favorable to the employees than the health care coverage required by sections 4 to 10, inclusive, of this act.

Sec. 6. (NEW) (*Effective October 1, 2005*) (a) There is created a State Health Insurance Purchasing Program. The program shall be managed by the Comptroller as part of the program authorized under subsection (i) of section 5-259 of the general statutes.

(b) Notwithstanding any other provisions of the general statutes, the Comptroller shall (1) administer the program and have exclusive responsibility for contract, budget and personnel matters, and (2) have fiduciary responsibility for the program, including exclusive fiduciary responsibility over the assets of the program. The Comptroller shall administer the program in a manner that will assure prompt delivery of benefits and related services to the enrollees and, if applicable, dependents.

(c) The Comptroller shall arrange coverage for enrollees and, if applicable, dependents eligible under sections 4 to 10, inclusive, of this act by establishing and maintaining a purchasing pool. The Comptroller shall negotiate contracts with those health care service plans and health insurers that choose to participate for the benefit package described in this section and shall not self-insure or partially self-insure the health care benefits under this section.

(d) The health care benefits coverage provided to enrollees and, if applicable, dependents shall be equivalent to the coverage required under subsection (a) or (b) of section 9 of this act.

(e) The program shall be funded by employer fees and enrollee contributions as described in sections 7 and 8 of this act. The Comptroller shall administer the program in a manner that assures that such fees and enrollee contributions are sufficient to fund the program, including administrative costs. The Comptroller shall develop and utilize appropriate cost containment measures to maximize the cost-effectiveness of health care coverage offered under the program.

Sec. 7. (NEW) (*Effective October 1, 2005*) (a) Except as otherwise provided in sections 4 to 10, inclusive, of this act, every large employer shall pay a fee as specified in this section.

(b) The Comptroller shall establish the level of the fee by determining the total amount necessary to pay for health care for all enrollees and, if applicable, their dependents eligible for the program established pursuant to section 6 of this act. In setting the fee, the Comptroller may include costs associated with the administration of the program, including those costs associated with collection of the fee and its enforcement by the Labor Department. The program shall be fully supported by the fees and enrollee contributions collected pursuant to this section and section 8 of this act. The fees and enrollee contributions collected pursuant to this section and section 8 of this act shall not be used for any purpose other than providing health coverage for enrollees and, if applicable, their dependents, as well as costs associated with the administration of the program and with collection of the fee and its enforcement by the Labor Department.

(c) The Comptroller shall provide notice to the Labor Department of the amount of the fee in a time and manner that permits the Labor Department to provide notice to all employers of the estimated fee.

(d) The Labor Department shall waive the fee of any employer that is entitled to a credit pursuant to section 9 of this act. Employers may apply for the credit in the manner prescribed by the department.

(e) Large employers shall pay a fee based on the cost of coverage for all enrollees and their dependents. The fee to be paid by each employer shall be based on the number of potential enrollees and, if applicable, dependents, using the employer's own workforce on a date specified by the Comptroller as the basis for the allocation, and on such other factors as the Comptroller may determine in order to provide coverage that meets the standards of sections 4 to 10, inclusive, of this act. To assist the Comptroller in determining the fee, each employer shall provide to the Comptroller information as specified by the Comptroller regarding potential enrollees and, if applicable, dependents.

(f) Coverage of an enrollee or, if applicable, his or her dependents shall not be contingent upon payment of the fee required pursuant to this section by the employer of that enrollee. If an employer fails to pay the required fee or the total amount of such fee, the employer shall pay the fund a penalty of two hundred per cent of the amount due and unpaid.

(g) In addition to the penalty pursuant to subsection (f) of this section, an employer shall pay interest on all amounts due and unpaid in accordance with the rate provided for unpaid contributions under chapter 567 of the general statutes.

(h) Nothing in this section shall preclude an employer from purchasing additional benefits or coverage, in addition to paying the fee.

Sec. 8. (NEW) (*Effective October 1, 2005*) (a) The applicable enrollee contribution, not to exceed twenty per cent of the fee assessed to the employer, shall be collected by the employer and paid concurrently with the employer fee. The employer may agree to pay more than eighty per cent of the fee, resulting in an enrollee and, if applicable, dependent contribution of less than twenty per cent. For enrollees making a contribution for family coverage and whose wages are less than two hundred per cent of the federal poverty guidelines for a

family of three, as specified annually by the United States Department of Health and Human Services, the applicable enrollee contribution shall not exceed five per cent of wages. For enrollees making a contribution for individual coverage and whose wages are less than two hundred per cent of the federal poverty guidelines for an individual, the applicable enrollee contribution shall not exceed five per cent of wages.

(b) The Comptroller shall establish the required enrollee and dependent deductibles, coinsurance or copayment levels for specific benefits, including total annual out-of-pocket costs.

(c) No out-of-pocket costs other than copayments, coinsurance and deductibles in accordance with this section shall be charged to enrollees and dependents for health benefits.

(d) In determining the required enrollee and dependent deductibles, coinsurance and copayments, the Comptroller shall consider whether the proposed copayments, coinsurance and deductibles deter enrollees and dependents from receiving appropriate and timely care, including those enrollees with low or moderate family incomes. The Comptroller shall also consider the impact of out-of-pocket costs on the ability of employers to pay the fee. This section applies to coverage provided through the program only and is not intended to apply to other coverage.

(e) In the event that the employer fails to collect or transmit the enrollee contribution in a timely manner, the employer shall become liable for a penalty of two hundred per cent of the amount that the employer has failed to collect or transmit, and the employee shall be relieved of all liability for that failure. The employer's failure to collect or transmit the required enrollee's contribution or to provide enrollment information about an employee shall not affect the employee's coverage. An employer shall only withhold and collect an amount for purposes of the program in accordance with the manner and at the times specified by the Labor Department pursuant to this

section. An employee for whom enrollment information is not otherwise received by the Comptroller may demonstrate eligibility for coverage by demonstrating employment to the satisfaction of the Comptroller. The Comptroller may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, for such purpose. To the extent feasible, the Comptroller and the Labor Department shall adopt procedures to facilitate the provision of information regarding the eligibility of enrollees and information regarding any failure of an employer to collect or transmit employee contributions as required by this section.

Sec. 9. (NEW) (*Effective October 1, 2005*) (a) An employer required to pay a fee under section 7 of this act may apply to the Labor Department for a credit against the fee by providing proof of coverage for eligible enrollees and, if applicable, their dependents consistent with sections 4 to 10, inclusive, of this act. Proof of coverage shall be demonstrated by any health care coverage that meets or exceeds the benefits of the program authorized for municipal employees under subsection (i) of section 5-259 of the general statutes.

(b) Nothing in this section shall preclude an employer from providing additional benefits or coverage.

(c) It shall be unlawful for an employer to designate an employee as an independent contractor or temporary employee, reduce an employee's hours of work, or terminate and rehire an employee to avoid the employer's obligations under sections 4 to 10, inclusive, of this act. An employer that violates this subsection shall pay to the fund a penalty of two hundred per cent of the amount of any fee that would have otherwise been paid by the employer, including for the period that the enrollee and, if applicable, dependents should have received coverage but for the employer's conduct in violation of this section.

(d) An employer shall not request or otherwise seek to obtain information concerning income or other eligibility requirements for public health benefit programs regarding an employee, dependent or

other family member of an employee, other than that information about the employee's employment status otherwise known to the employer consistent with existing state and federal law and regulation.

(e) The Labor Department shall adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to assure compliance by employers with this section.

(f) Any new employer or existing employer that previously was not subject to this section shall begin complying with all applicable provisions of this section not later than one month after the date it becomes subject to sections 4 to 10, inclusive, of this act.

(g) Any existing employer previously subject to sections 4 to 10, inclusive, of this act but no longer subject to said sections shall notify the Labor Department in a manner prescribed by that department not later than fifteen days after this change before discontinuing compliance with the provisions of sections 4 to 10, inclusive, of this act.

Sec. 10. (NEW) (*Effective October 1, 2005*) (a) Employers shall provide information to the Comptroller regarding potential enrollees and, if applicable, dependents as prescribed by the Comptroller to assist the Comptroller in obtaining information necessary for enrollment. The Comptroller shall not require the employer to obtain from the potential enrollee information about the family income or other eligibility requirements for public assistance programs or the HUSKY Plan, other than that information about the enrollee's employment status otherwise known to the employer consistent with existing state and federal law and regulation.

(b) The Comptroller shall obtain enrollment information from potential enrollees and, if applicable, dependents to be covered by the program. The enrollee may voluntarily provide information sufficient to determine whether the enrollee or dependents may be eligible for coverage under public assistance programs or the HUSKY Plan if the enrollee chooses to seek enrollment in those programs. The

Comptroller shall use a uniform enrollment form for obtaining that information. The Comptroller shall provide information to enrollees covered by the program regarding the coverage available under the program and other programs for which enrollees or dependents may be eligible.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2005*	New section
Sec. 2	*from passage*	New section
Sec. 3	*from passage*	New section
Sec. 4	*October 1, 2005*	New section
Sec. 5	*October 1, 2005*	New section
Sec. 6	*October 1, 2005*	New section
Sec. 7	*October 1, 2005*	New section
Sec. 8	*October 1, 2005*	New section
Sec. 9	*October 1, 2005*	New section
Sec. 10	*October 1, 2005*	New section

Statement of Purpose:

To establish a state-operated, affordable health insurance plan for people who are self-employed, work for a small company that does not offer health insurance coverage or uninsured, and to provide health care coverage for employees working for larger employers.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]